STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445238	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF TULLAHOMA	1715 N JACKSON ST TULLAHOMA, TN 37388

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey and investigation of complaint #33336, #33383, and #32882, was completed on May 21, 2014, at Life Care Center of Tullahoma. No deficiencies were cited related to complaint #33336 and #33383 under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days.	F 203	F203 1. Resident #221 is no longer a resident at the facility 2. On 5/22/2014 an audit of all residents who were involuntarily discharged for the previous 30 days was conducted by the Director of Admissions and Admission Nurse to ensure there was a notice of discharge given in writing and that it was documented in the record. No other residents were found out of compliance with discharge notice.	5/22/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE ED | (X6) DATE 6/11/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 203	Continued From page 1 The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to issue a thirty day notice prior to discharge for one resident (#221) of three residents reviewed for admission, transfer, and discharge rights. The findings included: Resident #221 was admitted to the facility on April 6, 2005, and readmitted on June 25, 2013, with diagnoses including Major Depressive Affective Disorder, specified as with Psychotic Behavior, Diabetes Mellitus, Hypertension, Polyneuropathy, and Morbid Obesity. Medical record review of a Certificate of Need for	F 203	3. On 6/3/14 Registered Nurses, Licensed Practical Nurses, and Social Service staff were in serviced by the Director of Nursing on ensuring that residents who are involuntarily discharging are given appropriate discharge notice and it is documented in their record. The Director of Admissions and Admission Nurse will conduct random audits weekly for 12 weeks to ensure compliance in maintained. 4. Results of audits will be reported monthly by the Director of Admissions and Admission Nurse to the Performance Improvement Committee which is comprised of Executive Director, Medical Director, Director of Nursing, and 3 other staff members for 3 months. The Executive Director will monitor this process monthly for 3 months to ensure compliance and make corrections as needed.	6/3/14 6/26/2014

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F 203	Continued From page 2 Involuntary Admission dated November 7, 2013, revealed "...I am a licensed physician...In my professional opinion, based on the examination and the information provided, I certify that this person is subject to Involuntary care and treatment...has a mental illness or serious emotional disturbance...antisocial behavior, Paranoia...roomate fears for life and had to be removed...intoxication - refused blood tests, refused psychiatric evaluations...violent outbreaks + (plus) actions to staff & employee. Inappropriate letters to staff. Paranoid ideations...threat to self and others...help refused multiple times...Requires direct transportation to an admitting psychiatric facility for a second certificate of need (CON) examination..." Interview on May 20, 2014, at 3:00 p.m., with the Administrator, in the Administrator's office, confirmed the facility had refused to readmit the resident and did not issue a thirty day letter of discharge to the resident. Telephone interview on May 21, 2014, at 3:15 p.m., with the psychiatric hospital's Social Worker, revealed the Social Worker had contacted the facility on November 15, 2013, as the resident was stabilized, and the facility had refused to readmit the resident to the facility. c/o #32882	F 203	F205 1. Resident #221 is no longer a resident at the facility 2. On 6/3/14 the Director of Nursing audited subsequent residents transferred to a hospital or therapeutic leave to ensure that the resident and their families receive a copy of Life Care of Tullahoma's Bed-hold policy in addition to the one given to them at admission.	6/3/14
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member	F 205		

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F 205	Continued From page 3 or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to issue the facility's Bed Hold Policy, upon hospital transfer, for one resident (#221), of three residents reviewed for admission, transfer, and discharge rights. The findings included: Resident #221 was admitted to the facility on April 6, 2005, and readmitted on June 25, 2013, with diagnoses including Major Depressive Affective Disorder, specified as with Psychotic Behavior, Diabetes Mellitus, Hypertension, Polyneuropathy, and Morbid Obesity. Medical record review of a physician's order dated November 7, 2013, revealed the resident was to be discharged to the hospital. Medical record review revealed no documentation	F 205	3. On 6/3/14 Registered Nurse, Licensed Practical Nurse, Social Service, and Admission staff were in serviced by the Director of Nursing to provide Life Care of Tullahoma's Bed-hold Policy to any resident, and their responsible party, that is transferred to a hospital or has a therapeutic leave. Printed copies of the bed-hold policy will be accessible at each nurses station. The Director of Nursing or designee will conduct random audits weekly for 12 weeks to ensure compliance in maintained. 4. Results of audits will be reported monthly by the Director of Admissions and Admission Nurse to the Performance Improvement Committee which is comprised of Executive Director, Medical Director, Director of Nursing, and 3 other staff members for 3 months. The Executive Director will monitor this process monthly for 3 months to ensure compliance and make corrections as needed.	6/3/14 6/26/2014

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F 205	Continued From page 4 the resident had been issued a copy of the facility's Bed Hold Policy. Review of the facility's Bed Hold Policy revealed "...At the time the Resident is to leave the Facility for a temporary stay in a hospital...the Resident/Legal Representative will be given a written copy of the Bed Hold Policy and may elect to hold open the Resident's room and bed until the Resident returns..." Interview on May 20, 2014, at 3:00 p.m., with the Administrator, in the Administrator's office, confirmed the facility did not issue the bed hold policy to the resident, at the time of discharge on November 7, 2013. c/o #32882	F 205		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation, and interview, the facility failed to ensure dignity was maintained by a staff member standing, not sitting beside, while assisting a resident to eat, for one resident (#162) of thirty-seven residents reviewed. The findings included:	F 241	**F 241** 1. On 5/19/2014 CNA #1 was educated by the Director of Nursing to sit and feed while assisting with meals with resident #162. 2. On 5/19/2014 no other residents were observed being fed by a CNA that was standing. 3. On 6/3/14 the Director of Nursing conducted an educational in service to Certified Nurse Assistants, Licensed Practical Nurse, Registered Nurse, and Therapy staff regarding the policy of feeding residents in effort to provide and be conscientious of dignity and respect of individuality of residents, specifically educated staff on proper meal assistance. The Director of Nursing or designee will conduct random audits 3 times a week for 12 weeks to ensure compliance.	5/19/2014 5/19/2014 6/3/14

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F 241	Continued From page 5 Resident #162 was admitted to the facility on August 22, 2013, with diagnoses including Chronic Systolic Heart Failure, Atrial Fibrillation, and Psychosis. Medical record review of the Quarterly Minimum Data Set dated April 18, 2014, revealed the resident required extensive assistance of one person for eating. Review of the policy, Feeding A Resident, revealed, "...Sit to feed the resident..." Observation on May 19, 2014, at 11:55 a.m., revealed the resident seated in a gerichair at the nursing station. Continued interview revealed Certified Nursing Assistant (CNA) #1 standing beside the resident feeding the resident lunch. Interview on May 19, 2014, at 1:10 p.m., with Licensed Practical Nurse (LPN) #1, at the nursing station, confirmed the CNA was not to feed the resident while standing over the resident.	F 241	4. Results of audits will be reported monthly by the Director of Nursing to the Performance Improvement Committee which is comprised of Executive Director, Medical Director, Director of Nursing, and 3 other staff members for 3 months. The Executive Director will monitor this process monthly for 3 months to ensure compliance and make corrections as needed.	6/26/2014
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279	F279 1. On 5/21/14 Resident #36 care plan was reviewed by the Director of Nursing to ensure the care plan accurately reflects the resident's fluid restriction status.	5/21/14

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F 279	Continued From page 6 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to develop a care plan to address the fluid restriction for one resident (#36) of thirty-seven residents reviewed. The findings included: Resident #36 was admitted to the facility on April 9, 2014, with diagnoses including End Stage Renal Disease, Diabetes Mellitus, Hypertension, Peripheral Vascular Disease, and Coronary Artery Disease. Review of the Nutrition Data Collection/Assessment, dated April 19, 2014, revealed the resident received a regular consistency, concentrated carbohydrate diet, with a 1200 milliliters (ml) fluid restriction. Review of the Physician's Orders dated May 1, 2014, through May 31, 2014, revealed, "...1200 ml/ (per) 24 hour fluid restriction..." Observation on May 20, 2014, at 3:30 p.m., in the resident's room revealed a thirty-two ounce water pitcher, half-full, on the over-bed table near the	F 279	2. On 5/21/14 the care plans of residents with fluid restrictions were audited by the Director of Nursing to ensure they accurately reflect the resident's fluid restriction status. No other resident's with fluid restriction care plans were observed as being inaccurate with the resident's fluid restriction status. 3. On 6/3/2014 he Director of Nursing conducted an educational in service to the nursing Staff regarding resident care plan accurately reflecting residents' fluid restrictions. The Director of Nursing will conduct random audits weekly for 12 weeks to ensure compliance in maintained. 4. Results of audits will be reported monthly by the Director of Nursing to the Performance Improvement Committee which is comprised of Executive Director, Medical Director, Director of Nursing, and 3 other staff members for 3 months. The Executive Director will monitor this process monthly for 3 months to ensure compliance and make corrections as needed.	5/21/14 6/3/2014 6/26/2014

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F 279	Continued From page 7 bed, and two six ounce cups partially filled with clear liquid. Review of the facility's policy, Fluid Restriction, revealed, "Fluid restrictions are coordinated between Nursing Services and Food and Nutrition Services. Diets are adjusted to comply with fluid restrictions..." Interview with the Director of Nursing on May 20, 2014, at 3:40 p.m., in the day room on the East Wing confirmed the fluid restriction should have been divided between shifts, including the fluids provided by dietary. Interview with the Registered Dietician via telephone on May 21, 2014, at 8:45 a.m., from the Human Resources office, confirmed the resident had been reviewed in the Resident At Risk meeting for non-compliance with fluid restriction. Continued interview confirmed the 1200 ml fluid restriction should have been on the care plan for guidance of who should have provided what amount of fluid in a specific timeframe. Continued interview confirmed the facility failed to develop a care plan to address the fluid restriction for resident #36.	F 279		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		

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F 323	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, review of the Material Safety Data Sheet (MSDS), facility policy review and interview, the facility failed to ensure potentially hazardous chemicals were stored in a safe, secure manner; and failed to ensure equipment was safe for one resident (#96) of thirty-seven residents reviewed. The findings included: Observation of the Biohazard Room on the North Wing on May 19, 2014, at 10:20 a.m., revealed the door was unlocked, and a quart-size spray bottle labeled "MPC Flashback Spray Buff", one-third full of clear liquid, was hanging on the handle of the floor buffer, stored in the Bio-Hazard Room. Review of the MSDS for Flashback FS revealed, the product was classified as a cleaning compound that could pose an immediate (acute) health hazard. Continued review revealed storage and handling information included, "...Keep out of reach of children...Avoid contact with eyes, skin, and clothing. Avoid breathing vapors...". Review of the facility's policy, Hazardous Materials Management Plan, revealed, "...The purpose and objectives of the Hazardous Materials and Waste Management Program are:...Minimizing risks to patients, visitors, personnel and the environment..." Interview on May 19, 2014, at 10:25 a.m., with the Housekeeping/Floor Technician, who came to	F 323	F323 1a. On 5/20/14 the Biohazard room was immediately locked and locking mechanism inspected to ensure proper functioning and chemicals were secured. 1b. Resident #96 received a new wheelchair and identified wheelchair was discarded. 2a. On 5/20/14 the Maintenance Director audited bio-hazard rooms to ensure they were locked and locks were functioning properly at closure. No other Bio-hazard rooms were observed defective and hazardous chemicals were in locked and secured locations. 2b. On 5/20/14 the Maintenance Director audited all the wheelchairs to observe if any wheelchair posed a hazard to safety. No other wheelchairs were observed defective or hazardous to safety. 3a. On 6/3/2014 the Director of Nursing conducted an educational in service to Certified Nurse Assistants, Licensed Practical Nurse, Registered Nurse, Therapy, and Environmental Services staff regarding the Environmental Service staff regarding immediately notifying Maintenance of Bio-hazard rooms that are not locking sufficiently. The Maintenance Director will conduct audits of Bio-hazard rooms weekly for 12 weeks to ensure that they are secured and locking properly at closure and that chemicals are stored in locked and secured locations to maintain compliance.	5/20/14 5/20/14 5/20/14 5/20/14 6/3/2014

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F 323	Continued From page 9 retrieve the buffer, confirmed the Bio-Hazard Room had been left unlocked, and the chemical spray had been left unsecured. Resident #96 was readmitted to the facility on January 10, 2014, with diagnoses including Paranoid Type Schizophrenia, Psychosis, Depressive Disorder, and Generalized Pain. Observation on May 19, 2014, at 1:50 p.m. revealed the resident seated in a wheelchair in the resident's room. Continued observation revealed the left side of the wheelchair skirt guard below the arm rest was loose with duct tape applied and a sharp edge was present on the top of the wheelchair skirt guard, and the right side of the wheelchair skirt below the arm rest was loose. Interview and observation on May 19, 2014, at 1:55 p.m., with Licensed Practical Nurse #2 (LPN) Unit Manager, in the resident's room, confirmed the wheelchair was in need of repair and was a safety hazard.	F 323	3b. On 6/3/2014 he Director of Nursing conducted an educational in service to the Certified Nurse Assistants, Licensed Practical Nurse, Registered Nurse, Therapy, and Environmental Services staff regarding wheel chair safety, specifically to remove any observed wheelchair from use that is defective or need of repair and notify Maintenance. The Maintenance Director will conduct audits of wheelchairs weekly for 12 weeks to identify safety hazards, wheelchairs identified will be removed from use and repaired as necessary to maintain compliance. 4. Results of audits will be reported monthly by the Director of Maintenance to the Performance Improvement Committee which is comprised of Executive Director, Medical Director, Director of Nursing, and 3 other staff members for 3 months. The Executive Director will monitor this process monthly for 3 months to ensure compliance and make corrections as needed.	6/3/2014 6/26/2014
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	F441 1. On 5/20/2014 Nursing Admin placed a sign instructing individuals to Stop was placed on the Resident # 109 door.	5/20/14

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 441	Continued From page 10 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, observation and interview, the facility failed to provide signage for isolation for one resident (#109), of thirty-seven residents reviewed. The findings included: Resident #109 was readmitted to the facility on April 22, 2014, with diagnoses including Lower Back Decubitus, Diabetes Mellitus, Peripheral Vascular Disease, Chronic Airway Obstruction, and Clostridium Difficile (C. diff - A bacteria that	F 441	2. On 5/20/2014 the Director of Nursing audited all residents with transmission based precautions to ensure compliance with posting of proper signage. 3. On 6/3/14 the Director of Nursing conducted an educational in service to the Registered Nurses, Licensed Practical Nurses on the Infection Control Policy and Procedures, specifically on proper signage on resident rooms with transmission based precautions. The Director of Nursing will conduct random audits 3 times a week for 12 weeks to ensure compliance in maintained. 4. Results of audits will be reported monthly by the Director of Nursing to the Performance Improvement Committee which is comprised of Executive Director, Medical Director, Director of Nursing, and 3 other staff members for 3 months. The Executive Director will monitor this process monthly for 3 months to ensure compliance and make corrections as needed.	5/20/2014 6/3/14 6/26/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 11 causes inflammation of the colon; can live for long periods on surfaces; highly infectious; and spread by contact with contaminated materials.) Medical record review of the laboratory test dated May 16, 2014, revealed the resident had a positive result for C. diff. Observation of the doorway outside the resident's room on May 20, 2014, at 7:28 a.m., revealed no indication the resident was on isolation precautions. Observation during the resident interview on May 20, 2014, at 7:28 a.m., in the resident's room revealed two large containers, one designated for linen with a red biohazard bag, and the other designated for garbage. Continued observation in the resident's room revealed a multi-drawer container near the door in the resident's room with personal protective equipment (gowns, masks, gloves). Review of the facility's policy, Standard and Transmission-based Precautions; Isolation Procedure, revealed, " ...Transmission-based precautions are used in addition to standard precautions for residents with suspected or confirmed infectious conditions. Residents are place on appropriate transmission-based precautions until the condition has been ruled out or the criteria for removal from isolation have been met ..." Continued policy review revealed requirements for "Contact Isolation" included, "Stop" sign on door. Interview with Licensed Practical Nurse #3 on May 20, 2014, at 7:30 a.m., confirmed the resident was in Contact Isolation for C.diff, and	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445238	A. BUILDING _____ B. WING _____	05/21/2014

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F 441	Continued From page 12 should have had a "Stop" sign posted on the resident's door.	F 441		